

MEMO

TO: Members, Senate Committee on Public Health, Senior Issues,  
Long-Term Care and Privacy  
FROM: Rob Gundermann, Public Policy Director  
Wisconsin Alzheimer's Association Chapter Network  
RE: Support of Senate Bill 283  
DATE: December 5, 2007

**Greater  
Wisconsin  
Chapter**  
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715-682-3974

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*Wausau*  
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608-232-3400  
800-272-3900

**Southeastern  
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Chapter**  
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Milwaukee  
414-479-8800  
800-272-3900

Good Afternoon Chairman Carpenter and members of the Committee. I'm Rob Gundermann, public policy director for the Wisconsin Chapters of the Alzheimer's Association. Thank you for the opportunity to speak today.

The Alzheimer's Association supports SB 283. We believe that creating minimum standards protects consumers by ensuring that specialized care, which is usually more expensive, can be understood by consumers to provide some basic level of care for people with dementia. Under current law it's very difficult for families to know what specialized care means and that makes it difficult to choose a good facility.

We feel minimum standards are necessary, as we still see basic problems such as unsecured units and units without adequately trained staff. We believe anyone claiming to offer specialized care should have at least one staff member on duty with training beyond that of a certified nursing assistant. Certainly some training would be expected in detection of pain in a patient group who can't speak and may not show symptoms we would commonly expect. An ombudsman called me this week to say she had seen cases of Alzheimer's patients on psychotropic medications because of behavior issues when the underlying problem was an infection. I think we could also all agree that a unit or wing offering specialized care for people with Alzheimer's disease needs to be secured in some way, either through a wander guard system, alarms, locks, something.

A lack of standards has also led to an uneven playing field on which some facilities provide excellent care while others provide little but may have excellent marketing materials. This has been unfair to the majority of facilities who are doing a very good job. This bill protects the consumer and levels the playing field.

Thank you for your time and consideration,  
Rob Gundermann, Public Policy Director  
Wisconsin Alzheimer's Association Chapter Network  
(608) 232-3408



**Wisconsin Association of Homes and Services for the Aging, Inc.**

204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

December 5, 2007

To: Senator Tim Carpenter, Chair  
Members, Senate Public Health, Senior Issues, Long-Term Care and Privacy Committee

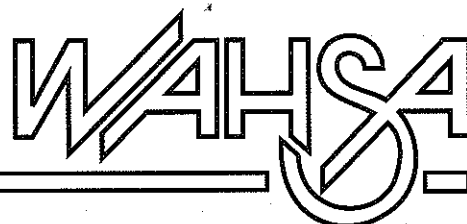
From: John Sauer, Executive Director  
Tom Ramsey, Director of Government Relations

Subject: WAHSA Opposition to 2007 Senate Bill 283

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and persons with a disability. Membership is comprised of 187 religious, private, fraternal and governmental organizations which own, operate and/or sponsor 196 nursing homes, 20 facilities for the developmentally disabled (FDD), 81 community-based residential facilities (CBRF), 59 residential care apartment complexes (RCAC), 14 HUD Section 202 Supportive Housing for the Elderly apartment complexes, 113 apartment complexes for independent seniors, and over 300 community service programs ranging from Alzheimer's support, child and adult day care, hospice and home care to Meals on Wheels. In our nursing homes alone, WAHSA members employ over 30,000 individuals who provide compassionate care and service to over 20,000 residents.

WAHSA members pride themselves on the quality of the care they provide their residents. Those that provide such care are especially proud of the care they provide their residents with Alzheimer's disease or related dementia. If they believed SB 283 would improve that care, they would support the bill. But until they know what the bill will do and who it will apply to, **WAHSA members respectfully oppose SB 283.**

When we queried our membership on whether they could support SB 283, they asked what the bill would do. When told it would establish standards for the care and treatment of people with Alzheimer's disease or related dementia, they indicated that sounded like a good idea and asked what those standards would be. But when told we wouldn't know what the standards would be until the Department of Health and Family Services (DHFS) developed them by rule AFTER SB 283 was signed into law, they asked how they could possibly support a bill that establishes care giving standards without any inkling of what those standards might be, what costs they might incur to comply with those unknown standards, or whether their current programs would meet the new standards.



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They asked who the bill would apply to. We indicated nursing homes, CBRFs, RCACs, adult family homes and hospices "which hold themselves out as providing special services" to persons with Alzheimer's disease or related dementia. They asked if that meant them; we stated we weren't certain. They asked how they could possibly support a bill that establishes care giving standards if they weren't even certain to whom those standards would apply.

They asked what problems existed to warrant the need for SB 283. When told we were not certain what problems SB 283 seeks to address, they asked how they could possibly support a bill which seeks a legislative solution to problems that they aren't even aware exist. And if such problems do exist, WAHSA members believe current regulations provide the DHFS with an array of enforcement tools to address those problems.

They asked if SB 283 were similar to a bill introduced in the 1991 legislative session. We responded that, indeed, SB 283 is virtually the same piece of legislation as 1991 Assembly Bill 864, introduced January 8, 1992 by Representative Peggy Krusick, except that AB 864 only applied to nursing homes. When asked what happened to 1991 AB 864, we indicated it died in committee, without even gaining the support of the Alzheimer's Association. It was the belief of those that opposed 1991 AB 864 that additional regulations were not the answer; what was needed was information that would enable consumers to make informed decisions when selecting a long-term care facility for the care and treatment of Alzheimer's disease. So rather than pass a bill, a group of providers and representatives of the Alzheimer's Association, the DHFS and the Board on Aging and Long-Term Care met informally over the next several years and developed a Guideline for Dementia Specific Care Program Disclosure Statement and a Consumer Checklist of "Important Questions to Ask About Dementia Specific Care." Our members suggested that rather than passing 2007 SB 283, convening a similar workgroup might be more productive. WAHSA would welcome the opportunity to refine such a checklist for use by consumers and providers.

Finally, they pointed to the current shift in the care and treatment of Alzheimer's disease from a medical model to a person-centered care model, combined with the fact we are learning more and more every day about this insidious disease and how it best can be treated, and questioned the wisdom of placing care and treatment standards in the administrative code when those standards might actually be obsolete by the time the SB 283-mandated rule is promulgated. We found that argument difficult to counter.

Until SB 283 satisfactorily addresses these questions and concerns, WAHSA members will oppose the bill.

In terms of the bill's specifics, we raise the following points:

- 1) On Page 2, line 7 of 2007 SB 283, how is "hold itself out as providing special services" defined? Does the bill apply only to those facilities which refer to themselves as providing special units for Alzheimer's disease or words to that effect? What "special services" does the bill include? Without clarifying this language, facilities will be unaware if they are required to satisfy the care and treatment standards the DHFS is required to develop by rule under SB 283.

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2) On Page 2, lines 15-17 of the bill, SB 283 requires the DHFS to consult with "residents" of nursing homes, CBRFs, RCACs, adult family homes and hospices before promulgating the care and treatment standards rule. Do these residents have to be stricken with Alzheimer's disease? While we appreciate the input the bill provides, we question the practicality of this provision.

3) If SB 283 applies specifically to Alzheimer's disease/dementia special care units, we question SB 283's applicability to RCACs and hospices. HFS 89.29(1) states that "no residential care apartment complex may admit any of the following persons, unless the person being admitted shares an apartment with a competent spouse or other person who has legal responsibility for the individual: (a) A person who has a court determination of incompetence and is subject to guardianship under ch. 880, Stats; (b) A person who has an activated power of attorney for health care under ch. 155, Stats; and (c) A person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions." RCAC tenants are expected to be capable of negotiating, signing and understanding a service agreement and a risk agreement. While there is no doubt some RCAC tenants have Alzheimer's disease or related dementia, very few have the disease upon admission to the RCAC and those that do only can be admitted if they share their apartment with a competent spouse or the individual who has legal responsibility for them. We would submit that virtually no RCACs in this state hold themselves out as providing special units for Alzheimer's disease. The RCAC is not the proper setting for most people with Alzheimer's disease and WAHSA members believe the provisions in SB 283 should not apply to RCACs. The same argument applies to hospices, whose sole function is to provide palliative and supportive care to those with terminal illness, regardless of the cause of that terminal illness.

4) On Page 5, lines 10-18 of the bill, the DHFS may promulgate the rule establishing care and treatment standards for people with Alzheimer's disease or related dementia as an emergency rule without requiring the Department to provide evidence that an emergency exists. It's been 15 years since a bill similar to SB 283 was last introduced and that bill failed. While there may be some problems with the care and treatment of those with Alzheimer's disease in this state, it seems rather outlandish to now declare the situation warrants the promulgation of an emergency rule.

WAHSA members renew our pledge to work with the authors of SB 283 and its companion bill, AB 493, to address any problems with the care and treatment that our Alzheimer's residents are receiving. We simply don't believe SB 283 is the appropriate vehicle to do so.

Thank you for this opportunity to testify on SB 283.

Attachments:

1991 Assembly Bill 864

A January 23, 1997 memo on the work of the Dementia Specific Care Committee

The Guideline for Dementia Specific Care Program Disclosure Statement

Consumer Checklist: Important Questions to Ask about Dementia Specific Care

HFS 89.29(1), Wis. Adm. Code

Alzheimer's Disease and Dementia Resources from the DHFS Web Site

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“Shifting from a Medical Model of Dementia Care to a New Culture of Person-Directed/Centered Care” (from the DHFS Person-Directed Dementia Care Behavior Solutions Advisory Committee)

Statistics on Skilled Nursing Facilities with Special Units for Alzheimer’s Disease from the DHFS Publication *Wisconsin Nursing Homes, 2005*



## 1991 ASSEMBLY BILL 864

January 8, 1992 - Introduced by Representatives KRUSICK, GROBSCHMIDT, HUBER, NOTESTEIN, SCHNEIDERS, URBAN and ROHAN, cosponsored by Senator VAN SISTINE. Referred to Committee on Aging.

- 1 AN ACT to create 50.04 (2u) of the statutes, relating to units within  
2 nursing homes for individuals with Alzheimer's disease or other  
3 dementias, granting rule-making authority and providing a penalty.

-----  
Analysis by the Legislative Reference Bureau

This bill prohibits a nursing home from holding itself out to the public as having a unit for the care or treatment of persons with Alzheimer's disease or other dementias unless the nursing home meets standards for the unit, promulgated by rule by the department of health and social services (DHSS). Violations of the prohibition are punishable by DHSS as a class "C" nursing home violation (requiring an administrative forfeiture of not more than \$100). Under the bill, DHSS must promulgate rules, after consulting with certain specified entities and groups, that establish standards for units within nursing homes for persons with Alzheimer's disease or other dementias.

For further information see the state and local fiscal estimate, which will be printed as an appendix to this bill.

-----  
The people of the state of Wisconsin, represented in senate and assembly,  
do enact as follows:

- 4 SECTION 1. 50.04 (2u) of the statutes is created to read:  
5 50.04 (2u) UNITS FOR ALZHEIMER'S DISEASE OR OTHER DEMENTIAS. (a) In  
6 this subsection:  
7 1. "Alzheimer's disease" has the meaning given in s. 46.87 (1)(a).  
8 2. "Dementia" means organic loss of human intellectual function.  
9 (b) No nursing home may hold itself out as having a unit of the  
10 nursing home for the care and treatment of individuals with Alzheimer's

1 disease or other dementias unless the nursing home meets standards for the  
2 unit that are established by rule under par. (d).

3 (c) This subsection does not restrict a nursing home from accepting  
4 for residency an individual with end-stage Alzheimer's disease and pro-  
5 viding care and treatment to that individual in a unit for general care in  
6 which he or she is appropriately placed.

7 (d) The department shall promulgate rules establishing standards for  
8 units within nursing homes for the care and treatment of individuals with  
9 Alzheimer's disease or other dementias after consulting with all of the  
10 following:

11 1. A private nonprofit corporation that is awarded a grant under s.  
12 46.855.

13 2. Consumers of nursing home services.

14 3. Advocates of nursing home residents.

15 4. Representatives of the nursing home industry.

16 (e) Violation of par. (b) is a class "C" violation under sub. (4) (b)  
17 3.

18 SECTION 2. NONSTATUTORY PROVISIONS; HEALTH AND SOCIAL SERVICES. (1)  
19 NURSING HOME ALZHEIMER'S UNIT RULES. The department of health and social  
20 services shall submit in proposed form the rules required under section  
21 50.04 (2u) (d) of the statutes, as created by this act, to the legislative  
22 council staff under section 227.15 (1) of the statutes no later than March  
23 1, 1993.

24 SECTION 3. EFFECTIVE DATES. This act takes effect on September 1,  
25 1992, except as follows:

26 (1) The treatment of section 50.04 (2u) (d) of the statutes and  
27 SECTION 2 of this act take effect on the day after publication.

28 (End)

# Dementia Specific Care Committee

January 23, 1997

John Sauer, Executive Director  
WI Assn. of Homes & Serv/Aging  
204 S. Hamilton Street  
Madison, WI 53703

Dear Mr. Sauer:

In 1992, Wisconsin Alzheimer Association Chapters convened a meeting with members of the Wisconsin Nursing Home Associations, The Board on Aging and Long-term care, CBRF, and Adult Day care providers to discuss the issue of Alzheimer Special Care Units in Wisconsin. Representatives from these agencies formed the Dementia Specific Care Committee to study issues related to specialized care for persons with dementia.

In 1994, this committee became a sub-group of the work group for Nursing Home Residents with Behavior Symptoms, currently called Adults with Behavior Symptoms in Long-Term Care - Wisconsin Workgroup and went on record to support a voluntary disclosure process for all specialized dementia care services and consumer education.

To accomplish this objective, it was determined:

- Providers of dementia specific care should voluntarily develop and use a disclosure statement to define the special care they provide.
- Consumers will be provided a dementia specific care check-list to assist in selection of an appropriate program. The check-list includes reference to a disclosure statement encouraging the consumer to request a written copy.
- Grant funding is being pursued to assist in distributing the check-list and disclosure statement.

The committee is requesting your organization to review the enclosed material and consider endorsement of the disclosure statement document. Please send us the written endorsement of your association by February 14, 1997 to Mary Bouche, 1725 Dousman St., Green Bay, WI 54303.

The Committee has received a Helen Bader Foundation Grant. Your endorsement will assist the committee to implement and promote the project.

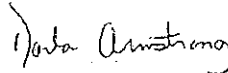
For your information, we are enclosing with this mailing a roster of current work group members and other agencies from which endorsement is being requested.

The disclosure statement and the list of endorsers will be distributed to consumers and providers of dementia specific care throughout the State of Wisconsin. It is the committee's intention that the use of the disclosure statement will outline for providers and consumers the special care that agency programs provide for dementia clients. Your public endorsement will help to ensure quality dementia specific care and consumer education.

Part of the Committee's focus is consumer and provider education. For the benefit of your members we are available to provide information or make a presentation at your next meeting/conference. If you have any interest please contact Darla Armstrong at 608-271-7321 or Mary Bouche at 414-498-2110.

We greatly appreciate your assistance and support in this matter. Please feel free to contact us with questions or ideas you may have.

Sincerely,



Darla Armstrong, Chairperson  
Dementia Specific Care Committee

Mary Bouche, Chairperson  
Wisconsin Alzheimer Association Network

DA/MB/af

Enclosures



*Someone to Stand by You*

## **GUIDELINE FOR DEMENTIA SPECIFIC CARE PROGRAM DISCLOSURE STATEMENT**

### **Alzheimer's Disease and Related Disorders**

An organization that claims to offer special care programs for persons who have Alzheimer's disease or other related disorders, shall provide a written document disclosing the additional care provided in each of the following areas:

**Philosophy** - a statement of overall philosophy and mission which reflects the needs of the residents.

**Pre-admission, Admission and Discharge** - the process and criteria for placement, transfer or discharge from the program.

**Assessment, Care Planning and Implementation** - the process used for assessment and establishing the plan of care and its implementation.

- a. Therapeutic programming (activities, personal care, etc.)
- b. Clinical support services (nutrition, therapies, medical, restraint use, etc.)
- c. Changes in condition

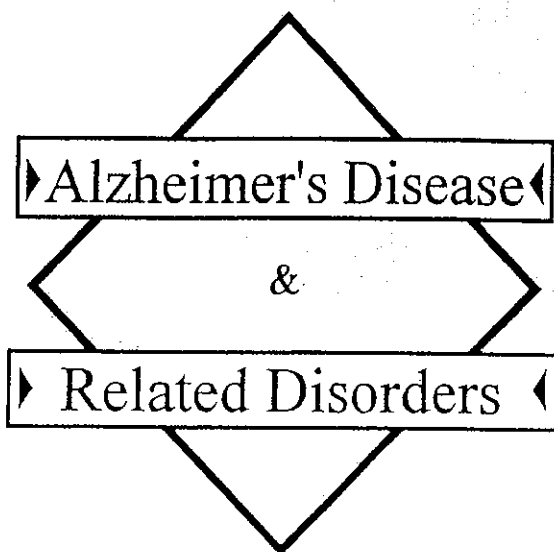
**Staffing Patterns and Staff Education** - training and continuing education practices.

**Physical Environment** - the design features that support the functioning of cognitively impaired adults, accommodate behaviors, maximize functional abilities, promote safety, and encourage independence.

**Family Role in Care** - the involvement of families and availability of family support programs.

**Costs** - the cost of care and any additional fees.

**THE DISCLOSURE STATEMENT SHALL BE MADE AVAILABLE TO ANY  
PERSON SEEKING PLACEMENT IN A SPECIAL CARE PROGRAM.**



## *Consumer Checklist*

*Important  
Questions  
To Ask  
About  
Dementia  
Specific  
Care*



### DEMENTIA SPECIFIC CARE PROGRAMS

Are you unsure of how to decide on the best care for your loved one? Are you afraid to ask certain questions, or even unsure of what all of your choices may be? This checklist was designed to assist you in seeking out the most informed answers to your questions. You may wish to use this checklist as you tour different dementia specific care programs. The best way to begin the selection process is to be well informed. By seeking out the proper information, you can feel confident that you are making a sound decision.

This checklist asks questions which may be of interest to you when seeking the services of dementia specific care programs offered by:

- ♦ Adult Day Care Programs
- ♦ Assisted Living Facilities
- ♦ Community Based Residential Facilities (CBRF)
- ♦ Nursing Homes

The checklist addresses all of the topics which should be included in a program disclosure statement. Make a list of the facilities in your community that offer dementia specific care programs. If at all possible, visit two or three specialized care programs before choosing the one that's right for you.

There are several community organizations you may contact to assist you in choosing a program. A list of these organizations is included at the end of this brochure.

**CARE PLANNING AND IMPLEMENTATION**

	YES	NO
Are care plan meetings held to positively address care issues?	<input type="checkbox"/>	<input type="checkbox"/>
Is the family/guardian involved in these?	<input type="checkbox"/>	<input type="checkbox"/>
Are the person's preferences for daily routine considered?	<input type="checkbox"/>	<input type="checkbox"/>
Is medication:		
♦ monitored?	<input type="checkbox"/>	<input type="checkbox"/>
♦ stored in a safe manner?	<input type="checkbox"/>	<input type="checkbox"/>
♦ used for behavior management?	<input type="checkbox"/>	<input type="checkbox"/>
Is a log of medication kept?	<input type="checkbox"/>	<input type="checkbox"/>
Can the person retain their personal physician?	<input type="checkbox"/>	<input type="checkbox"/>
Is transportation provided for medical appointments?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a plan to respond to emergency medical needs?	<input type="checkbox"/>	<input type="checkbox"/>
Is specialized therapy provided if needed? (Physical, Speech, or Occupational)	<input type="checkbox"/>	<input type="checkbox"/>
Is there a monitoring system for medical care?	<input type="checkbox"/>	<input type="checkbox"/>
Is there an incontinence program to maintain a person's freedom and dignity?	<input type="checkbox"/>	<input type="checkbox"/>
Are restraints used?	<input type="checkbox"/>	<input type="checkbox"/>

**CHANGE IN CONDITION ISSUES**

Will diminished abilities result in transfer or discharge from the program?	<input type="checkbox"/>	<input type="checkbox"/>
Is there care for the late stage?	<input type="checkbox"/>	<input type="checkbox"/>
Is there care provided during illness?	<input type="checkbox"/>	<input type="checkbox"/>
Are families kept informed of changes in condition?	<input type="checkbox"/>	<input type="checkbox"/>

**FOOD SERVICE**

	YES	NO
Is a daily menu available?	<input type="checkbox"/>	<input type="checkbox"/>
Are nutritional needs monitored?	<input type="checkbox"/>	<input type="checkbox"/>
Are modified diets provided?	<input type="checkbox"/>	<input type="checkbox"/>
Is assistance provided for those who cannot feed themselves?	<input type="checkbox"/>	<input type="checkbox"/>
Are meals attractively presented and served?	<input type="checkbox"/>	<input type="checkbox"/>

**SUCCESS INDICATORS**

Do/Are the persons receiving care:

♦ Appear relaxed and content?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Alert and engaged in activities?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Dressed appropriately?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Clean and well groomed?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Are family support groups offered?	<input type="checkbox"/>	<input type="checkbox"/>

**FINANCES**

Does the admission agreement clearly specify the following:

♦ A list of services included in the monthly rate?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Daily or monthly rate?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Additional charges for services not covered in the rate?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Is there an admission or entrance fee?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Is the admission fee entirely refundable?	<input type="checkbox"/>	<input type="checkbox"/>
♦ Does the rate change if more care is needed?	<input type="checkbox"/>	<input type="checkbox"/>

## PHILOSOPHY

	YES	NO
Does the program have a mission or program statement?	<input type="checkbox"/>	<input type="checkbox"/>
Does the program have a Disclosure Statement? (Ask for copies)	<input type="checkbox"/>	<input type="checkbox"/>
Does the facility have licenses you consider necessary?		
♦ State Licensure	<input type="checkbox"/>	<input type="checkbox"/>
♦ Medicare Certification	<input type="checkbox"/>	<input type="checkbox"/>
♦ Medicaid Certification	<input type="checkbox"/>	<input type="checkbox"/>
♦ Private Accreditation	<input type="checkbox"/>	<input type="checkbox"/>

## ADMISSIONS

What are the admission requirements? (Ask for a list)		
Do other program participants appear to have functional capabilities similar to those of your family member?	<input type="checkbox"/>	<input type="checkbox"/>
Will an assessment be done for your loved one by staff to determine special dementia care needs?	<input type="checkbox"/>	<input type="checkbox"/>
Is the location of the facility convenient for family/friends?	<input type="checkbox"/>	<input type="checkbox"/>

## STAFFING PATTERNS AND EDUCATION

	YES	NO
Is Alzheimer/dementia specific education available for all staff?	<input type="checkbox"/>	<input type="checkbox"/>
Does the number of staff appear adequate?	<input type="checkbox"/>	<input type="checkbox"/>
Are staff pleasant and encouraging to residents?	<input type="checkbox"/>	<input type="checkbox"/>
Are staff able to handle difficult behavioral problems?	<input type="checkbox"/>	<input type="checkbox"/>

## THE PHYSICAL ENVIRONMENT

Is the environment safe?	<input type="checkbox"/>	<input type="checkbox"/>
Is outdoor space available and used?	<input type="checkbox"/>	<input type="checkbox"/>
Is private space personalized and respected?	<input type="checkbox"/>	<input type="checkbox"/>
Are belongings safe and available for personal use?	<input type="checkbox"/>	<input type="checkbox"/>
Is the environment calm and pleasurable?	<input type="checkbox"/>	<input type="checkbox"/>
Are there areas to allow wandering and freedom of movement?	<input type="checkbox"/>	<input type="checkbox"/>
Would you have reservations about having family and friends visit the facility?	<input type="checkbox"/>	<input type="checkbox"/>

## ACTIVITIES

Is there a daily calendar of therapeutic activities?	<input type="checkbox"/>	<input type="checkbox"/>
Are there individualized and small group activities?	<input type="checkbox"/>	<input type="checkbox"/>
Are individual interests and abilities accommodated?	<input type="checkbox"/>	<input type="checkbox"/>
Are there opportunities for community outings?	<input type="checkbox"/>	<input type="checkbox"/>
Are there religious services available?	<input type="checkbox"/>	<input type="checkbox"/>

## OTHER REFERRAL AGENCIES

Board on Aging and Long Term Care  
(BOALTC)  
214 North Hamilton Street  
Madison, WI 53703  
1-800-242-1060

Bureau of Aging & Disability  
Resources  
P. O. Box 7851  
Madison, WI 53707  
1-608-267-9583

Notes

This brochure was developed by a group of professionals in the state of Wisconsin dedicated to the care of persons with dementia. The project is supported by a generous grant from the Helen Bader Foundation.

## ALZHEIMER'S ASSOCIATION CHAPTER NETWORK

Indianhead Chapter  
Eau Claire  
1-715-835-7050  
1-800-499-7050

Lake Superior Chapter  
Ashland  
1-715-682-6478  
1-800-682-6478

Midstate Wisconsin Chapter  
Marshfield  
1-715-389-3200

North Central Wisconsin Chapter  
Wausau/Rhineland  
1-715-848-1221 - Wausau  
1-715-362-7779 - Rhineland  
1-800-200-1221

Northeastern Wisconsin Chapter  
Green Bay (after July 1, 1997)  
1-414-498-2110 1-920-498-2110  
1-800-360-2110

Riverland Chapter  
LaCrosse  
1-608-784-5011  
1-800-797-1656

South Central Wisconsin Chapter  
Madison  
1-608-232-3400  
1-800-428-9280

Southeastern Wisconsin Chapter  
Milwaukee  
1-414-479-8800  
1-800-922-2413



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changes that would necessitate a change in the service or risk agreement. The review may be initiated by the facility, the county department designated under sub. (3) (c) 2., or at the request of or on the behalf of the tenant.

**History:** Cr. Register, February, 1997, No. 494, eff. 3-1-97; am., Register, November, 1998, No. 515, eff. 12-1-98.

**HFS 89.27 Service agreement. (1) REQUIREMENT.** A residential care apartment complex shall enter into a mutually agreed-upon written service agreement with each of its tenants consistent with the comprehensive assessment under s. HFS 89.26.

**(2) CONTENTS.** A service agreement shall identify all of the following:

(a) *Services.* 1. The type, amount and frequency of the services to be provided to the tenant, including services which will be available to meet unscheduled care needs.

2. Any additional services which are available for purchase by the tenant.

3. The activities and social connections the tenant will be assisted in maintaining.

(b) *Fees.* 1. The charge for the services covered by the service agreement, both individually and in total, and the time and amount of any fee increase that will occur during the period covered by the service agreement. Facilities shall remind tenants of any fee increase by written notice 30 days in advance of the effective date.

2. Any supplemental fees for services not covered in the service agreement or other agreement between the facility and the tenant.

(c) *Policies and procedures.* 1. 'Additional services'. a. Types of additional services which the facility would make available or which the facility would assist in arranging for a tenant during acute episodes, following release from the hospital or during other periods when the tenant may experience temporary needs.

b. Policies and procedures regarding services which the tenant arranges to receive from providers other than the residential care apartment complex.

2. 'Termination or transfer'. Grounds for termination of the contract between the tenant and the facility or relocation of the tenant to another residence and the procedure for tenant participation in decisions regarding termination and relocation. Conditions for termination contained in the service agreement shall not be contrary to the requirements relating to contract termination contained in s. HFS 89.29 (3).

3. 'Tenant's rights'. The residential care apartment complex's policies relating to tenant rights, including at a minimum, the rights identified in subch. III.

4. 'Dispute resolution'. The facility's internal grievance procedure for resolving tenant complaints.

**(3) OTHER SPECIFICATIONS.** (a) Only services selected and agreed to by the tenant may be included in the service agreement.

(b) A service agreement may not waive any of the provisions of this chapter or other rights of the tenant.

(c) The service agreement shall be presented in language and a format that make it possible for tenants to readily identify the type, amount, frequency and cost of services they receive, the qualifications of the staff providing those services and whether the services are provided directly by the facility or by subcontract.

(d) The initial service agreement and any renewals of the service agreement shall be dated and signed by a representative of the facility; by the tenant or by the tenant's guardian, if any, and all other persons with legal authority to make health care or financial decisions for the tenant; and by the county for a tenant whose services are funded under s. 46.27 (11) or 46.277, Stats. The facility shall provide a copy of the service agreement to all parties who signed the agreement.

**Note:** Persons with legal authority to make health care or financial decisions for the tenant include agents designated under an activated power of attorney for health care under ch. 155, Stats., and durable power of attorney under s. 243.10, Stats.

(e) The service agreement shall be completed by the date of admission.

**(4) REVIEW AND UPDATE.** The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement.

**History:** Cr. Register, February, 1997, No. 494, eff. 3-1-97; am., Register, November, 1998, No. 515, eff. 12-1-98.

**HFS 89.28 Risk agreement. (1) REQUIREMENT.** As a protection for both the individual tenant and the residential care apartment complex, a residential care apartment complex shall enter into a signed, jointly negotiated risk agreement with each tenant by the date of occupancy.

**(2) CONTENT.** A risk agreement shall identify and state all of the following:

(a) *Risk to tenants.* 1. Any situation or condition which is or should be known to the facility which involves a course of action taken or desired to be taken by the tenant contrary to the practice or advice of the facility and which could put the tenant at risk of harm or injury.

2. The tenant's preference concerning how the situation is to be handled and the possible consequences of acting on that preference.

3. What the facility will and will not do to meet the tenant's needs and comply with the tenant's preference relative to the identified course of action.

4. Alternatives offered to reduce the risk or mitigate the consequences relating to the situation or condition.

5. The agreed-upon course of action, including responsibilities of both the tenant and the facility.

6. The tenant's understanding and acceptance of responsibility for the outcome from the agreed-upon course of action.

(b) *Unmet needs.* Any needs identified in the comprehensive assessment which will not be provided for by the facility, either directly or under contract.

(c) *Notice regarding enforcement in registered facilities.* For registered facilities only, notice that the department does not routinely inspect registered facilities or verify their compliance with this chapter and does not enforce contractual obligations under the service or risk agreements.

**(3) NO WAIVER OF RULES OR RIGHTS.** A risk agreement may not waive any provision of this chapter or any other right of the tenant.

**(4) OBLIGATION TO NEGOTIATE IN GOOD FAITH.** Neither the tenant nor the facility shall refuse to accept reasonable risk or insist that the other party accept unreasonable risk.

**(5) SIGNED AND DATED.** The risk agreement shall be signed and dated by both an authorized representative of the residential care apartment complex and by the tenant or the tenant's guardian and agents designated under an activated power of attorney for health care under ch. 155, Stats., and durable power of attorney under s. 243.10, Stats., if any.

**(6) UPDATING.** The risk agreement shall be updated when the tenant's condition or service needs change in a way that may affect risk, as indicated by a review and update of the comprehensive assessment, by a change in the service agreement or at the request of the tenant or facility.

**History:** Cr. Register, February, 1997, No. 494, eff. 3-1-97; am., Register, November, 1998, No. 515, eff. 12-1-98.

**HFS 89.29 Admission and retention of tenants.**

**(1) ADMISSION.** No residential care apartment complex may admit any of the following persons, unless the person being admitted shares an apartment with a competent spouse or other person who has legal responsibility for the individual:

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(a) A person who has a court determination of incompetence and is subject to guardianship under ch. 54, Stats.

(b) A person who has an activated power of attorney for health care under ch. 155, Stats.

(c) A person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions

Note: This requirement is included because tenants need to be competent to understand and express their needs and preferences, enter into a service agreement and understand and accept risk.

(1m) FAMILY CARE INFORMATION AND REFERRAL. If the secretary of the department has certified that a resource center, as defined in s. HFS 10.13 (42), is available for the residential care apartment complex under s. HFS 10.71, the residential care apartment complex shall provide information to prospective residents and refer residents and prospective residents to the aging and disability resource center as required under s. 50.034 (5m) to (5p), Stats., and s. HFS 10.73.

(2) RETENTION. (a) A residential care apartment complex may retain a tenant whose service needs can be met by the facility or can be met with services made available by another provider.

(b) A residential care apartment complex may retain a tenant who becomes incompetent or incapable of recognizing danger, summoning assistance, expressing need or making care decisions, provided that the facility ensures all of the following:

1. That adequate oversight, protection and services are provided for the individual.

2. That the tenant has a guardian appointed under ch. 54, Stats., or has an activated power of attorney for health care under ch. 155, Stats., or a durable power of attorney under s. 243.10, Stats., or both. The activated power of attorney for health care or durable power of attorney shall, either singly or together, substantially cover the person's areas of incapacity.

3. That both the service agreement and risk agreement are signed by the guardian and by the health care agent or the agent with power of attorney, if any.

Note: Facilities are permitted the option of retaining tenants who become incompetent or incapable of recognizing danger, summoning assistance, expressing need or making care decisions because familiar surroundings and routines are an important component of dementia care and in order to accommodate aging in place.

(c) No owner, operator, staff member or family member of a person connected with a residential care apartment complex may serve as a guardian, representative payee or other financial conservator for a tenant of the facility.

(3) TERMINATION OF CONTRACT. (a) *Reasons.* A residential care apartment complex may terminate its contract with a tenant when any of the following conditions apply:

1. Except as provided under par. (b), the tenant's needs cannot be met at the level of service which facilities are required to make available to tenants under s. HFS 89.23 (2).

2. Except as provided under par. (b), the time required to provide supportive, personal and nursing services to the tenant exceeds 28 hours per week.

3. Except as provided under par. (b), the tenant's condition requires the immediate availability of a nurse 24 hours a day.

4. The tenant is adjudicated incompetent under ch. 54, Stats., has an activated power of attorney for health care under ch. 155, Stats., or has been found to be incapable of recognizing danger, summoning assistance, expressing need or making care decisions by 2 physicians or by one physician and one licensed psychologist who have personally examined the tenant and signed a statement specifying that the person is incapable.

5. The tenant's behavior or condition poses an immediate threat to the health or safety of self or others. Mere old age, eccentricity or physical disability, either singly or together, are insufficient to constitute a threat to self or others.

6. The tenant refuses to cooperate in an examination by a physician or licensed psychologist of his or her own choosing to deter-

mine his or her health or mental status for the purpose of establishing appropriateness for retention or termination.

7. The tenant's fees have not been paid, provided the tenant and the tenant's designated representative, where appropriate, were notified and given reasonable opportunity to pay any deficiency.

8. The tenant refuses to enter into a negotiated risk agreement or refuses to revise the risk agreement when there is a documented and significant medical reason for doing so.

9. The presence of any condition identified as grounds for termination in the service agreement, provided that these grounds are not inconsistent with requirements contained in subds. 1. to 8.

(b) *Supplemental services as an alternative to termination.* A residential care apartment complex shall not terminate its contract with a tenant for a reason under par. (a) 1. to 3. if the tenant arranges for the needed services from another provider consistent with s. HFS 89.24 (2) (b) and any unmet needs or disputes regarding potentially unsafe situations are documented in a risk agreement.

(c) *Procedures for termination.* 1. a. Except as provided under subd. 2., a residential care apartment complex shall provide 30 days advance notice of termination to the tenant and the tenant's designated representative, if any. If there is no designated representative, the facility shall notify the county department of social or human services under s. 46.21, 46.22 or 46.23, Stats.

b. Notice of termination shall include the grounds for termination and information about how to file a grievance consistent with the termination and grievance policies and procedures contained in the service agreement.

c. The 30-day notice period required for termination may include the period covered by a notice of nonpayment of fees and opportunity to pay any deficiency as required under par. (a) 7., provided that notice of termination is included with the notice of non-payment of fees.

2. No 30-day notice is required in an emergency. In this subdivision, "emergency" means an immediate and documented threat to the health or safety of the tenant or of others in the facility.

(d) *Failure to meet requirements of this chapter.* If the requirements of this chapter are violated by either the facility or the tenant, the party which is not in violation may terminate the contract on 30 days written notice without financial penalty.

History: Cr. Register, February, 1997, No. 494, eff. 3-1-97; am., Register, November, 1998, No. 515, eff. 12-1-98; corrections in (1) (a), (2) (b) 2. and (3) (a) 4. made under s. 13.93 (2m) (b) 7., Stats., Register October 2007 No. 622.

**HFS 89.295 Variance for demonstration projects in family care pilots.** (1) In this section, "variance" means permission to meet a requirement of this subchapter by an alternative means.

(2) The purpose of a variance granted under this section is to demonstrate efficient ways of delivering and assuring the quality of supportive, personal and nursing services in conjunction with delivery of the family care benefit as defined in s. 46.2805 (4), Stats.

(3) The department may grant a variance to a requirement of this subchapter when it is demonstrated to the satisfaction of the department that granting the variance is consistent with the purpose of the demonstration and will not jeopardize the health, safety, welfare or rights of any resident in the residential care apartment complex. The department may place a time limit and conditions on the variance.

(4) A request for variance shall be submitted to the department in writing and shall include all of the following:

(a) The efficiencies and quality assurance approaches to be demonstrated through the variance.

(b) Identification of each requirement from which the variance is requested.

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## Alzheimer's Disease and Dementia Resources

### Programs and Services

- [Alzheimer's Family and Caregiver Support Program](#)
- [Community Options Program](#)

### Person-Directed Dementia Care Behavior Solution Study

- [Person-Directed Dementia Care Assessment Tool \(PDE-84\)](#) (PDF, 303 KB)
- [Webcast 1: Introduction to Person-Directed Dementia Care](#)
  - Additional Material: [Powerpoint](#)
- [Webcast 2: Developing Person-Directed Dementia Care Plans](#)
  - Additional Material: [Powerpoint](#)
  - [Applying Person-Directed Care Principles to the Care Planning Process for People with Dementia](#) (PDF, 84 KB)

### Resource Materials:

- [20 Questions - Favorite Things](#) (PDF, 18 KB)
- [Behavior Analysis Form](#) (PDF, 15 KB)
- [Behavior Monitoring Record](#) (PDF, 22 KB)
- [Dementia Special Care Environment Initial Action Plan Development Directions and Sample](#) (PDF, 25 KB)
- [Guide for the Use of Disguised Doors and Other Preventive Exiting Strategies for People with Dementia](#) (PDF, 185 KB)
- [Guidelines for a Listening and Learning Circle](#) (PDF, 17 KB)
- [Lewy Body and Frontal-Temporal Lobe Dementias](#) (PDF, 18 KB)
- [Odor Control Guidelines for Special Care Units](#) (PDF, 18 KB)
- [Personal Alarms: Safety Device or Hazard?](#) (PDF, 29 KB)

- [Special Care Unit Live Activity Engagement Process and Pacing Throughout the Day](#) (PDF, 106 KB)
- [Shifting from a Medical Model of Dementia Care to a New Culture of Person-Directed/Centered Care](#) (PDF, 25 KB)
- [Sample Dementia Special Care Environment Working Document](#) (PDF, 34 KB)
- [Template for Special Care Environment Working Document](#) (PDF, 23 KB)
- [The Person-Directed Dementia Care Behavior Solutions Advisory Committee](#) (PDF, 17 KB)

## **Publications**

The following publications were developed as part of an Alzheimer's Demonstration Grant from the federal Administration on Aging.

- [Alzheimer's Caregivers Training Manual](#)
- [Dementia and Aggressive/Abusive Behavior Summit](#)
- [Dementia Care at Home Planning Guide](#)
- [Dementia Care Newsletter](#)
- [Dementia Quality of Life Outcomes Planning Tool](#)
- [Quality Home Visits Guide for Care Managers](#) (PDF, 71 KB)

## **Other Publications and Links**

- [Choosing Health Care Providers and Facilities](#) (exit DHFS)
- [Guide to Selecting an Adult Day Center](#) (exit DHFS)
- [National Alzheimer's Disease Awareness Month](#) (exit DHFS)
- [Publications from demonstration grants in other states](#) (exit DHFS)
- [Web sites on aging and dementia](#)
- [Wisconsin's Older Dementia Population](#) (PDF, 5 KB)

PDF: The free *Acrobat Reader*® software is needed to view and print portable document format (PDF) files. [Learn more.](#)

## Shifting from a Medical Model of Dementia Care to a New Culture of Person-Directed/Centered Care

### Disease vs. Disability

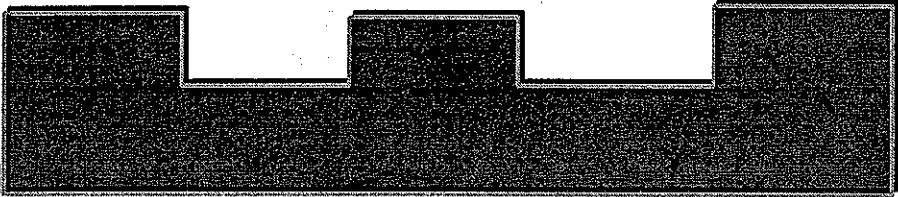
In order to provide true quality of life for people with dementia, it is necessary for us to shift our way of thinking from focusing on dementia as a disease that is degenerative without a cure - to focusing on the whole person, and seeing dementia as a disability of certain parts of the person's brain. In this way we can still have the whole person to work with where improvements in the person's abilities are possible, and continued use of their strengths essential.

The following model was developed by Christa Monkhouse, a Swiss nurse, as a way to present this concept visually and factually in a way that depicts how eldercare is being handled in most world countries from a medical perspective. The model also shows the rationale for shifting how care is focused in the future. Please refer to the visual depiction of the model as you read the next section.

1. **Acute/Intensive Care:** Imagine that you have just been in a terrible accident and are near death. You will need the most intensive care that you can get. There will be a need for expert doctors, nurses, technologies, medications, etc., and you will probably either be unconscious or barely able to interact with others. This means that your need for medical care is very high, and your need for life (shown at the bottom of the column) is very tiny (maybe only a five minute visit is all you could handle).
2. **Medical Floor Care:** Now that you have recovered a bit and are able to get up, walk, talk, eat, etc. you are transferred to a medical floor. At this point you may still be very weak and need close monitoring by doctors and nurses, but you can also begin to tolerate a little more visiting, phone calls, etc. so your need for life increases - as in the second column (though it is still small).
3. **Rehabilitation Care:** In this phase of your healing you are beginning to resume some of your daily routine and prepare for going back to your life outside of the medical facility. Now the focus is on therapy much more than on the doctors, nurses and medical monitoring you once needed. As you can see by the column number three, your need for life increases dramatically at this point. You are being shifted to a routine and stabilization pattern that you can maintain for a long period of time as the healing is nearly completed. It could actually impede your healing if you were to NOT have an increase in life activities with people who matter to you and activities that you enjoy.
4. **Long Term Care:** Once you have graduated to long term care - a need for some medical support, but not an intensive need - your need for life is the greatest need that you have. For this reason, it only makes sense that you be surrounded by people who know how to provide quality of life activities and support for you to do things that you enjoy and are good at. The need for medical care is very small in comparison.

Unfortunately, the premise of this model shows that by placing people in environments such as nursing homes, with primarily staff who monitor medical needs as employees, we are depriving people who live there of a certain level of quality of life. For people with dementia, this can lead to difficult behavior, depression, fast declines in ability and premature death. It is vital that we begin to recognize the need for life that exists and begin to shift the focus of care from measuring a person's medical declines and deficits to restoring a quality of life that a person can thrive on. Currently there is very little focus on social and emotional needs and no measures, as medical needs have.

This is the cultural shift from medical model dementia care to a person centered care culture of life.

1.	ICU	2.	MED FL	3.	REHAB	4. Long Term Care/ HOME/ADC	
A	DOCTORS	DOCTORS	DOCTORS	THERAPY	MEDICATIONS		C
C	MEDICATIONS	MEDICATIONS	MEDICATIONS	OT/PT/ST	NURSES-MDS		H
U	MEDICAL TX	MEDICAL TX	MEDICAL TX	TRIAL VISITS @ HOME	MONTHLY BI-ANNUAL VISITS		R
T	NURSES	NURSING	NURSING	MEDICATIONS	DOCTORS		O
E	BED REST	GET OUT OF BED	HOURLY MONITOR	NURSES	NURSES		N
	IV'S						I
	MONITOR EVERY 5 MINUTES						C

Example:

Under the current medical model we have highly trained nurses, nursing assistants, doctors and other medical professionals who keep track of things like vital signs, medications, behavioral displays, amounts of food eaten, voiding and the like. All of these things are carefully charted and measured.

In this environment a person with dementia is not as capable of asking clearly for what s/he needs due to disability of some parts of the brain, so it is very common for the basic needs a person has to be overlooked. The four universal needs not usually met for people with dementia are:

- The need to be useful
- The need to care (for others/self)
- The need to give and receive love
- The need to have self-esteem boosted

Imagine on one hand a person with dementia. She is crying out over and over "Help me, help me".

Imagine on the other hand the nursing staff and aides responding to this behavior. They might check:

- Is she wet?
- Is she hungry?
- Is she sick?
- Is she constipated? (etc.)

Let us imagine that all of her physical needs have been met. After investigation the nursing staff and aides conclude that this is something that they have to label and report on, so they call it "attention seeking behavior". How do you suppose this influences their behavior? It would be natural for them all to stay away from the person with dementia and not "reinforce" the behavior.

Imagine that you are the person with dementia – what need might you be trying and reaching out in the only way you know how to have recognized? The need to give and receive love? Let's say that is it. What might you do? Well, as the staff avoid you, your cries get louder and louder, you may throw yourself on the floor or hit or spit.....and your need is for life.

There is a vital need to have people who are trained on providing life – not just medical care.

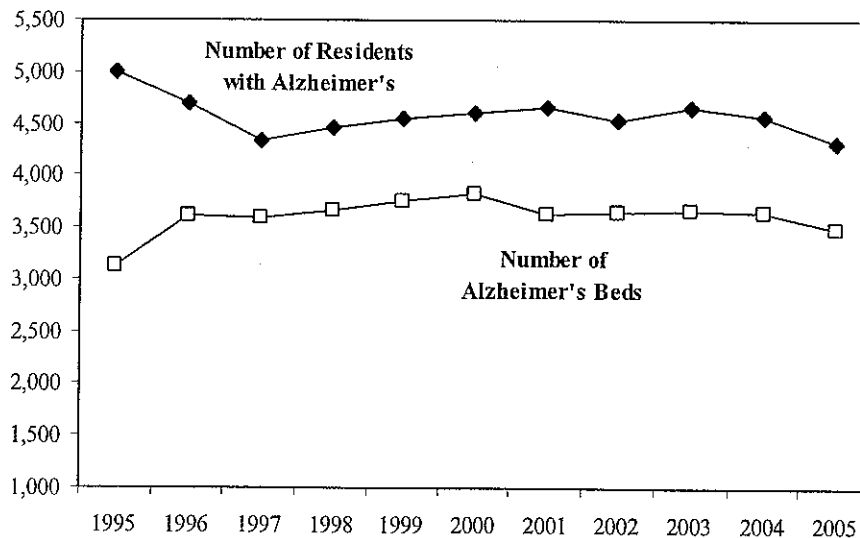
*Model developed by Christa Monkhouse, a Swiss nurse who works on culture change with organizations in Switzerland, Austria and Germany. Presented in a lecture given by Jane Verity, Founder and President of Dementia Care Australia 8/05.*

**Table 5. Skilled Nursing Facilities with Special Units for Alzheimer's Disease, Wisconsin 1995-2005**

Year	Number of Facilities	Percent of Facilities	Number of Alzheimer's Beds	Total Residents With Alzheimer's
1995	91	22%	3,123	5,004
1996	108	26	3,607	4,686
1997	111	26	3,590	4,336
1998	118	28	3,663	4,454
1999	124	30	3,756	4,547
2000	133	32	3,821	4,595
2001	126	31	3,633	4,649
2002	127	32	3,649	4,536
2003	128	32	3,670	4,655
2004	126	32	3,638	4,556
2005	122	31%	3,489	4,316

Source: Annual Survey of Nursing Homes, Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services.

**Figure 4. Number of Alzheimer's Beds and Nursing Home Residents with Alzheimer's, Wisconsin 1995-2005**



Source: Annual Survey of Nursing Homes, Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services.

- The number of nursing home beds in self-designated special units for Alzheimer's decreased by 149 beds (4 percent) in 2005, while the total number of nursing home residents with a primary diagnosis of Alzheimer's decreased by 240 (5 percent).
- From 1995 to 2005, the number of beds in special units for Alzheimer's disease increased 12 percent, while the number of nursing home residents with a primary diagnosis of Alzheimer's decreased 14 percent. There were 1.2 nursing home residents with Alzheimer's for every Alzheimer's bed in 2005, down from 1.6 for each bed in 1995.

**Table 6. Specialized Capacity of Skilled Nursing Facilities by County, Wisconsin 2005**

County of Location	Medicare-Certified Facilities	Medicare-Certified Beds	Alzheimer's Units	Alzheimer's Beds	Total Number Of Alzheimer's Residents on 12/31
<b>State Total</b>	<b>371</b>	<b>35,082</b>	<b>122</b>	<b>3,489</b>	<b>4,316</b>
Adams	1	102	0	0	9
Ashland	2	229	1	43	21
Barron	5	376	3	58	91
Bayfield	1	75	0	0	17
Brown	12	925	4	155	183
Buffalo	2	131	0	0	17
Burnett	2	133	0	0	16
Calumet	3	200	1	12	24
Chippewa	6	351	0	0	25
Clark	4	439	2	54	90
Columbia	5	512	3	80	69
Crawford	2	161	0	0	27
Dane	21	1,823	6	186	198
Dodge	10	1,033	2	68	97
Door	3	209	2	39	24
Douglas	4	432	2	84	42
Dunn	2	106	2	32	26
Eau Claire	6	633	1	11	84
Florence	1	73	0	0	1
Fond du Lac	9	698	5	105	110
Forest	2	141	2	38	17
Grant	9	632	4	62	70
Green	3	301	1	24	26
Green Lake	3	208	1	12	25
Iowa	3	182	1	25	15
Iron	1	70	0	0	14
Jackson	2	145	1	24	29
Jefferson	4	299	1	27	38
Juneau	3	196	2	28	33
Kenosha	9	1,041	1	48	120
Kewaunee	2	132	0	0	4
La Crosse	7	623	3	116	99
Lafayette	1	97	1	11	16
Langlade	1	168	1	31	2
Lincoln	3	334	1	24	35
Manitowoc	6	658	2	53	108
Marathon	7	887	2	82	110
Marinette	6	583	4	66	56
Marquette	1	46	0	0	8
Milwaukee	42	5,621	16	594	586
Monroe	4	323	2	37	29

(Continued)

**Table 6. Specialized Capacity of Skilled Nursing Facilities by County, Wisconsin 2005**

County of Location	Medicare-Certified Facilities	Medicare-Certified Beds	Alzheimer's Units	Alzheimer's Beds	Total Number Of Alzheimer's Residents on 12/31
Oconto	4	268	3	42	28
Oneida	3	315	2	56	20
Outagamie	9	992	3	86	108
Ozaukee	5	259	1	48	57
Pepin	2	118	0	0	10
Pierce	5	260	1	18	32
Polk	5	413	1	17	71
Portage	2	201	0	0	22
Price	2	103	1	28	24
Racine	6	724	2	133	98
Richland	2	132	1	11	11
Rock	10	793	2	52	88
Rusk	2	134	0	0	14
St. Croix	9	562	1	10	79
Sauk	5	466	1	24	75
Sawyer	2	135	0	0	9
Shawano	4	368	2	26	43
Sheboygan	8	908	1	20	79
Taylor	3	226	0	0	15
Trempealeau	5	350	2	35	54
Vernon	4	328	1	15	44
Vilas	1	79	1	24	15
Walworth	8	648	1	60	81
Washburn	2	140	0	0	12
Washington	5	691	2	108	88
Waukesha	15	1,883	4	171	140
Waupaca	8	616	4	129	128
Waushara	1	78	1	24	4
Winnebago	9	934	4	123	157
Wood	5	630	0	0	99

Source: Annual Survey of Nursing Homes, Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services.

Note: This table shows two aspects of specialized capacity among skilled nursing facilities: (1) facilities that are certified to provide Medicare-reimbursed care, and the number of beds for which they are certified to provide this care; and (2) facilities with self-designated special Alzheimer's units, and the number of beds in those units. Menominee County is not listed because there are no nursing homes in that county.

- In 2005, five counties had a growth rate of 20 percent or higher in the number of Medicare-certified beds: Richland, Walworth, Clark, Marathon, and Ozaukee. Statewide, the number of Medicare-certified beds increased 1 percent from 2004.
- Nursing homes in Kenosha, Dodge, Oconto, Marathon, Winnebago, Waupaca, Lafayette, and Brown counties increased their number of Alzheimer's beds by at least 20 percent from the previous year.
- Forty-nine counties had more nursing home residents with Alzheimer's than Alzheimer's beds on December 31, 2005, and 17 counties had no specialized Alzheimer's units. Twenty-one counties had more Alzheimer's beds than Alzheimer's residents on December 31, 2005.

## Nursing Home Residents

**Table 21. Percent of Nursing Home Residents by Age and Primary Disabling Diagnosis, Wisconsin, December 31, 2005**

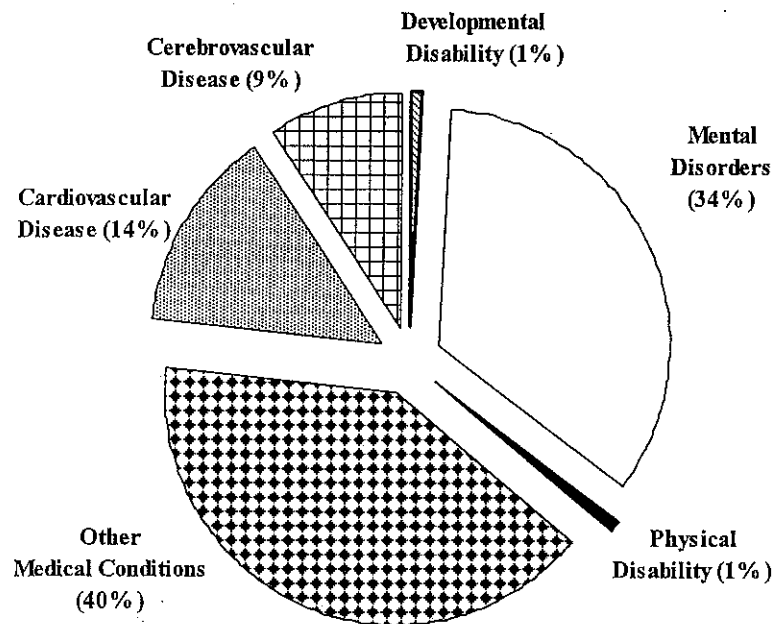
Primary Disabling Diagnosis	Age Group						Total
	<55	55-64	65-74	75-84	85-94	95+	
Mental Retardation	3	2	1	<1	<1	0	<1
Cerebral Palsy	2	2	1	<1	<1	0	<1
Epilepsy	<1	<1	<1	<1	<1	0	<1
Autism	<1	0	0	<1	0	0	<1
Multiple Developmental Disabilities	1	<1	<1	<1	0	0	<1
Other Developmental Disabilities	1	<1	<1	<1	<1	0	<1
<b>Subtotal of Developmental Disabilities</b>	<b>8</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>&lt;1</b>	<b>0</b>	<b>1</b>
Alzheimer's Disease	<1	3	8	14	15	12	13
Other Organic/Psychotic	4	8	10	14	18	20	15
Organic/Non-Psychotic	4	3	1	1	1	1	1
Non-Organic/Psychotic	13	11	8	3	2	1	4
Non-Organic/Non-Psychotic	2	2	1	2	1	1	2
Other Mental Disorders	<1	<1	<1	<1	<1	<1	<1
<b>Subtotal of Mental Disorders</b>	<b>24</b>	<b>27</b>	<b>28</b>	<b>34</b>	<b>37</b>	<b>36</b>	<b>34</b>
Paraplegic	1	1	<1	<1	<1	<1	<1
Quadriplegic	3	1	<1	<1	<1	0	<1
Hemiplegics	1	1	1	1	<1	<1	<1
<b>Subtotal of Physical Disabilities</b>	<b>5</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>&lt;1</b>	<b>&lt;1</b>	<b>1</b>
Cancer	3	2	3	3	2	2	2
Fractures	3	3	4	5	5	5	5
Cardiovascular Disease	3	6	8	12	17	22	14
Cerebrovascular Disease	8	12	12	10	9	6	9
Diabetes	4	5	8	6	4	2	5
Respiratory Diseases	3	5	6	5	5	4	5
Alcohol & Other Drug Abuse	1	<1	1	<1	<1	<1	<1
Other Medical Conditions	39	30	26	23	22	23	24
<b>Subtotal of Medical Conditions</b>	<b>64</b>	<b>65</b>	<b>68</b>	<b>64</b>	<b>62</b>	<b>64</b>	<b>64</b>
<b>Total Percent</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Number of Residents</b>	<b>1,222</b>	<b>1,677</b>	<b>3,463</b>	<b>10,575</b>	<b>14,381</b>	<b>3,024</b>	<b>34,342</b>

Source: Annual Survey of Nursing Homes, Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services.

Notes: Percentages are calculated separately for each age group and may not add to 100 percent due to rounding.

- Thirteen percent of nursing home residents had a primary diagnosis of Alzheimer's disease in 2005. Of these, 57 percent were age 85 and older (not shown).
- Thirty-four percent of nursing home residents had a primary diagnosis of mental disorders (including Alzheimer's disease) in 2005. Of these, 55 percent were aged 85 and older (not shown).

**Figure 14.** Percent of Nursing Home Residents by Primary Disabling Diagnosis, Wisconsin, December 31, 2005



Source: Annual Survey of Nursing Homes, Bureau of Health Information and Policy, Division of Public Health, Department of Health and Family Services.

- Twenty-three percent of nursing home residents had cardiovascular or cerebrovascular disease as their primary diagnosis in 2005, the same percentage as in 2004.
- The number of residents with a primary diagnosis of Alzheimer's disease decreased 5 percent in 2005, slightly more than the overall decrease in residents (3 percent). Alzheimer's disease is included in the mental disorders category in Figure 14.
- Only 2 percent of nursing home residents had cancer as their primary disabling diagnosis. These residents were included in the other medical conditions category in Figure 14.